Ethical issues in travel medicine

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George Edward Moore [Principia Ethica, 1903]

“It appears to me that in Ethics, as in all other philosophical studies, the difficulties and disagreements, of which history is full, are mainly due to a very simple cause: namely to the attempt to answer questions, without first discovering precisely what question it is which you desire to answer.”
Travel medicine is a BROAD topic; my focus is on medical tourism

Scope of travel

- To seek healthcare – patients / ‘clients’
- To deliver healthcare for gain, or altruism (voluntourism) – health-care workers

Both

- Affected by ease and speed of international travel and communication associated with globalization
- Raise questions about continuity of care & issues related to cultural, language & legal differences
- Raise concerns about ethics

Medical tourism

- Relatively recent phenomenon of travelers leaving family and friends to seek healthcare abroad, frequently in less developed countries, and the organizations that support or offer incentives for such travel
Historical context: Ancient Egypt / Greece

Ancient Egypt: highly sought sophisticated medical expertise

Ancient Greece: worshippers of Aesclepius (God of medicine) made pilgrimages to his temple in Epidaurus where they underwent healing

17th C emergence of spa towns in appealing places like the Pyrenees attracted the wealthy from all over Europe

Etc, etc, etc …
Globalization of travel

Projected international tourist arrivals worldwide from 1995 to 2030

Tourist arrivals in millions

- **Africa**
- **Middle East**
- **Americas**
- **Asia & the Pacific**
- **Europe**

© Statista 2015
Globalization of travel
‘Categories’ of medical tourism include those services that:

[I. Glenn Cohen ‘Patients with Passports: Medical tourism, Law, and Ethics’]

• Are legal in both home and destination countries (e.g. hip replacements, cardiac bypass, plastic surgery, tooth implants, cosmetic dentistry)

• Are illegal in the home country but legal in the destination country (e.g. abortion, assisted suicide, stem cell treatments) – ‘circumvention medical tourism’

• Are illegal in both home and destination countries (e.g. organ trafficking)
Popular destinations for medical tourism

- Brazil
- Costa Rica
- India
- Mexico
- Panama
- Singapore
- South Africa
- Thailand
Medical ethics: Principlism
(Beauchamp & Childress: Principles of Medical Bioethics, 1979)

• Four principles:

  – Autonomy – respect the right of patients to make informed decisions about their bodies

  – Beneficence – obligation to act in patient’s best interest

  – Non-maleficence – requirement to minimize harm (based on Hippocratic Oath)

  – Justice – requirement of fairness in the treatment of patients, colleagues and the community
Examples of categories of medical tourism

• Reproductive tourism
• Non-cosmetic dentistry
• Non-cosmetic surgery
• Transplantation
• Stem cell therapy
• Cosmetic dentistry
• Cosmetic surgery

Etc.
Reproductive tourism

- Termination of pregnancy
- Infertility treatments
- Sex selection
- IVF versus adoption
- Surrogacy
"Wait a minute, this prescription is for a dozen oysters and half an ounce of powdered rhino horn!"

I'm sorry I spent your entire college fund trying to conceive you.
Ethical issues: organ transplantation 1; philosophy of organ donation

- Transplantation ethics: philosophy that systematizes, defends & recommends concepts of right and wrong conduct related to organ donation

- Increasing demands for organs calls for bio-ethically acceptable new & innovative laws, policies and strategies of increasing organ supply

- In organ transplantation, role of altruism & medical ethics values are significant to societal welfare
  - Altruism (French ‘autrui’ – other people): living for others; neural bases for altruism
  - Two types: (i) obligatory: moral duty to help others, (ii) supererogatory: morally good, but not mortally required going ‘above and beyond’ one’s duty

[Act that maximizes good consequences for the majority of society is ‘utilitarianism’]
Ethical issues: organ transplantation 2

Need for transplantable organs far exceeds supply worldwide

- E.g. in US, Jan-April 2008: 9029 transplants from 4578 donors with 99,393 candidates on nationally coordinated transplant list [http://www.optn.org]

Less rigorous methods of organ distribution in some countries termed ‘transplant tourism’

- Transplant recipients (majority: kidney) more likely to be male, college educated, nonresident/foreign resident, self-funded)
- US: analysis of kidney & liver transplants to non-resident showed liver candidates to have shorter times to transplant & self-paying, the shortest time [Transplantation2 007;84:1548-14556]
- Notion that deceased donor organs are a ‘national resource’
Ethical issues: organ transplantation 3; illegal trafficking

- Adverse events – insufficient information regarding outcomes of medical care abroad; infectious and non-infectious complications – Whose responsibility? Whose cost (both individual and country levels)? What is the legal recourse?

- Shortages of organs are a universal problem (e.g. Spain that has a well-developed program can meet only 50% of demand); other models involving living donors must be explored – regulated, prevent organ vending, protect the donor and be transparent

- Where do the organs come from? Possibility that organs from deceased ‘donors’ are from executed prisoners (notably China) or from criminal rackets

- Duty of travel medicine practitioner to inform patient of risks and where possible mitigate risks (e.g. offer relevant immunizations)
Organ transportation / trafficking
Ethical issues: stem cell tourism

- Patient travel to receive stem cell treatments typically not available in home country
- Therefore sought in countries with more permissive regulatory environments (e.g. China, Thailand, South Korea, Panama, Costa Rica)
- Mainly autologous stem cell injections (marrow, adipose tissue etc. cells, cultured, ‘treated’, & administered):
  - Touted as effective in broad array of diseases, from CVS to neurodegenerative e.g. MS, Parkinson’s, Alzheimer’s; despite lack of science patient testimonials bolster success claims
  - Generally expensive
- For some patients, unproven treatments are the ‘last option’; Physician’s duty for informed decision-making is
  - Provide patients opportunity to choose among all available options & referring patient to reliable online resources
  - Assist patients with asking the right questions to assess veracity of advertising claims, what clinics are offering, whether facilities are accredited/approved, risks of procedure & possible side effects especially if these occur when patient gets treatment in another country (the traveler)
Aesthetic (cosmetic) medicine; historical context: ‘Beauty Doctors’
Aesthetic/cosmetic surgery
Ethical issues: aesthetic surgery 1

Chung et al, in a systematic review of plastic surgery, found only 110 articles in a pool of >100,000 that deal with ethics.


Aesthetic (cosmetic) surgery is requested to (i) satisfy patient's desire, and (ii) address patient's psychological & psychosocial needs, perceptions and expectations.

Interventions enhance patient's life, not 'save' it, i.e. aesthetic procedures perceived as a tool to fulfil wishes instead of relieving suffering or treating illness.

Aesthetic surgery is primarily a business, guided by a market ethic aimed at material gain and profit and not necessarily part of the healthcare system.

Medical tourism in tango paradise: The internet branding of cosmetic surgery in Argentina

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This article examines the online marketing literature that promotes Argentina as a rising destination for cosmetic surgeries. The surgical production of “body capital” is branded as an investment practice towards increasing one's value in the global market economy. Online advertisers portray Argentina as a familiar place where foreigners can feel “at home” due to an assumed “cultural affinity” (i.e., racial, ethnic and cultural similarities) with their Argentine hosts. Argentines are depicted as surgically enhanced role models to be imitated by their foreign visitors. The notion of
Ethical issues: aesthetic surgery 2

• Restriction of aesthetic surgery to the ‘rich’ counteract notions of distributive justice

• Inherent conflicts of interest may interfere with balanced information, detailing pros and cons, required for informed consent

• Patients seek out surgeon for interventions so, if fully informed by surgeon, autonomy is assumed but a competent patient may have unrealistic expectations, ignore risks, or seek services on basis of misconceptions about their body image

• If patient is a traveler who has the obligation to correct these beliefs?
### Table. Classification of Ethical Issues in Rhinoplasty

<table>
<thead>
<tr>
<th>Principle</th>
<th>Ethical Issues in Rhinoplasty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respect for autonomy</td>
<td>Informed consent for surgery</td>
</tr>
<tr>
<td></td>
<td>Digital photographs for documentation</td>
</tr>
<tr>
<td></td>
<td>Realistic and achievable goals communicated with patient and family</td>
</tr>
<tr>
<td></td>
<td>Confidentiality</td>
</tr>
<tr>
<td></td>
<td>Respecting patient’s requests</td>
</tr>
<tr>
<td></td>
<td>Adequate time during consultation to communicate expected outcomes, length of recovery, possible complications</td>
</tr>
<tr>
<td>Beneficence</td>
<td>Surgical competence in achieving desired goals</td>
</tr>
<tr>
<td></td>
<td>Judicious use of new techniques instead of time-tested methods</td>
</tr>
<tr>
<td></td>
<td>Understanding patient’s motivations (psychological, emotional, physical)</td>
</tr>
<tr>
<td></td>
<td>Possessing tools necessary to perform the operation safely and optimally</td>
</tr>
<tr>
<td></td>
<td>Consultation with others as needed</td>
</tr>
<tr>
<td>Nonmaleficence</td>
<td>Surgical competence in achieving desired goals</td>
</tr>
<tr>
<td></td>
<td>Intraoperative decision making</td>
</tr>
<tr>
<td></td>
<td>Recognition of one’s own limits</td>
</tr>
<tr>
<td></td>
<td>Disclosure of surgical errors immediately</td>
</tr>
<tr>
<td></td>
<td>Referral to other surgeons as needed</td>
</tr>
<tr>
<td></td>
<td>Doing what is needed, but no more</td>
</tr>
<tr>
<td>Justice</td>
<td>Honest dictations reflecting work actually done</td>
</tr>
<tr>
<td></td>
<td>Avoidance of deceiving insurance companies</td>
</tr>
<tr>
<td></td>
<td>Avoidance of instigating or validating discontent for another surgeon in an already dissatisfied patient</td>
</tr>
<tr>
<td></td>
<td>Knowledge of professional behavior regulations</td>
</tr>
</tbody>
</table>

[^1]: Adapted from Adedeji et al.[17]

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### The Rhinoplasty Surgeon’s Template for Resolving Ethical Problems

- **Case.** What are the facts and circumstances pertinent to this patient?
- **Dilemma.** What is the precise ethical issue? Are the decisions being made in the patient’s best interests?
- **Alternatives.** What are reasonable alternatives? Are there nonsurgical options? Is surgery the best option?
- **Key considerations in applying the 4 principles:**

  **Autonomy.** What are the patient’s wishes and values? Consider the patient’s understanding and expectations of the procedure. Explore his or her goals, hopes, and fears. If the patient is incapable of communicating the specific goals, this may be a negative prognostic indicator.

  **Beneficence/Nonmaleficence.** What can actually be done for your patient? Consider the patient’s previous operations, skin thickness, bony and cartilaginous framework, static and dynamic nasal airway, and any nonsurgical alternatives to achieve the goals. Will quality of life be improved?

  **Justice.** Is the patient being treated fairly? Would he or she truly benefit from a septrhinoplasty to address the airway (ie, significant caudal septal deviation) instead of a simple septrhinoplasty? If asked to consult on an unsatisfactory result, avoid instigating anger in the patient, who may need a corrective operation. Work within professional regulatory guidelines.

  **Should others be involved?** Consider familial support since a dissatisfied family can transfer negative feelings postoperatively to the patient, who will inevitably transfer those negative feelings to the surgeon. Would the support of other medical or paramedical professionals be helpful?

  **Propose a resolution.** Although most people are “good” candidates for rhinoplasty, there are few “perfect” candidates. Weigh the options and decide whether to proceed and in what fashion. Is there a probable net benefit for the patient?

  **Consider your choice critically.** Consider opinions of peers, your conscience, and emotional reactions. Are all parties involved, including yourself, comfortable with this decision? If not, what are the alternatives? Consider consulting with colleagues, ethical specialists, administration, or attorneys.

  **Do the right thing based on your knowledge, experience, and values.**
She who knows not, nose not ...
Dental tourism 1

- Driven by multiple socioeconomic factors: lack of access & cost
  - Is another example of globalization although, for convenience purposes, occurs along regional pathways vs. global networks (e.g. UK => C Europe)
  - Un-affordability of private dental care in many countries
  - Need for timely dental treatment
  - Patient realization that lower prices don’t necessarily equate to low quality care
  - ‘Word of mouth/ [😊]; internet; dental tourism companies offering ‘all-inclusive deals’
    - ‘Packages’: pre-established dental fees, air fare, ground transportation, accommodation, ‘VIP treatment’, restaurant reservations & side trips to tourist attractions
Dental tourism 2

- Quality of care ranges from excellent to substandard
- Variability in standards of training, accreditation & licensing of dentists
- Patients must
  - Be wary of substandard procedures
  - Understand that episodic nature of treatment undermines continuum of care especially as multiple procedures are compressed into abbreviated period
  - Understand difficulties in returning to international clinics for further treatment; local practitioners may not be willing to treat problems associated with care by dentist in another country (medico-legal liability)
  - Understand that often they must sign waiver of liability forms
  - Know that to initiate medico-legal action patient must turn to courts of country wherein clinic is located
- Mechanisms are required to protect vulnerable clients from possible adverse consequences of dental tourism
Dental tourism
Medical safaris: (i) voluntourism

JustUsFriends Medical Safari’s

JustUsFriends is now offering Medical Safari’s to East Africa. Ultimately we are changing the concept of volunteering by offering a safe and exciting adventure for medical professionals and their families. These safari’s are exclusively offered through AJT Tanzania, Ltd (African Journey Tours).

JustUsFriends is a nonprofit 501(c)(3) organization working to address critical global issues by providing meaningful and sustainable volunteer services to international communities, and contributing responsibly to local economies.

We use medical volunteers across the globe to treat children and adults alike in our small medical clinics and local hospitals located in Tanzania, Africa. We offer assistance in medical training and practices as well as educational assistance to the local healthcare providers with medications, treatments, and cures. Our goal is to leave a legacy of trained medical professionals, surgical equipment and professional partnerships to expand local medical infrastructures and create self-reliance in the developing world.

Our Medical Safari’s can be scheduled for 10-days, 15-days or longer. Examples of typical medical safari’s in Tanzanian Africa are as follows:

From the USA: Depart your nearest hometown airport for Kilimanjaro International Airport. From the US it will take approximately 24 hours to get to Africa.

14-Day Mission - Cost $6,000 USD plus airfare

Day 1  Arrive in Tanzania (Kilimanjaro International Airport which is located between the towns of Arusha and Moshi). You will be met by the JUF Country Coordinator and taken to our compound in Maji Chai, which is about a 15 minute ride from the airport.

Day 2  Work in the Loren’s Hope Medical Clinic or at one of our partner private hospitals.

Day 3  Leave Maji Chia and travel to Tarangire for a Culture and Nature experience.

Day 4  Travel to Lake Manyara Clinic. Culture and Nature tour.

Day 5  Work in Lake Manyara Clinic

Day 6  Culture and Nature at Ngorongoro Crater Area

Day 7  Work in Lake Manyara Clinic

Day 8  Culture and Nature in Serengeti area

Day 9  Work at Lake Manyara Clinic

Day 10  Drive back to Lake Manyara area

Day 11  Return to JUF Maji Chai compound
Voluntourism: The Kaci Hickox’s Case

- MSF Nurse arriving at Newark’s Liberty airport on 24 Oct 2014: initially no fever and completely asymptomatic; questioned, subsequently 1 elevated temperature reading, third temperature reading normal. EVD blood test negative. ‘Detained’ in a tent at airport for days before being allowed to return home to Maine.
- In Maine: home quarantine policy imposed restricting freedom of movement.
- WHO & CDC guidelines (latter endorsed by AMA, AHA, ANA), APIC, MSF do not support mandatory home quarantine of asymptomatic HCWs exposed to EVD (daily temperature readings & reporting of symptoms, however, necessary).
- Hickox argument for opposing State restrictions are the unjust, unconstitutional and unscientific impositions of the quarantine rule; broader arguments about dis-incentivizing and stigmatization of relief workers. Press has a field day.
- Public opinion differs … Poll commissioned by CBS News shows 80% of respondents think U.S. citizens and legal residents returning from W Africa should be quarantined ...
- U.S. Legal Opinion varied [http://www.medpagetoday.com/Practice Management/Medicolegal/48381] but majority support for Courts to defer to scientific principles, public health expertise, weigh up the risk of contagion versus the individual’s right to freedom & ensure that government does not abuse quarantine powers.
Kaci Hickox’s Case: U.S. Isolation and Quarantine

- Protection of the public by prevention of exposure to those with communicable infectious diseases
- Isolation: separates people with a suspected/confirmed contagious disease from those who do not have it
- Quarantine: separates and restricts movement of people exposed to a contagious disease to monitor if they become sick
- Right of the State to take action affecting individuals for the benefit of society
  - US: Commerce Clause of U.S. Constitution, Section 361 Public Heath Service Act (42 U.S. Code § 264): Secretary of Health & Human Services has authority to take measures to prevent entry & spread of communicable diseases into the U.S. and between States
  - Notion of ‘police power’ derived from the right of the State to take action affecting individuals for the benefit of Society
  - Federal, state, local & tribal health authorities enforce isolation and quarantine
  - CDC has authority to detain, medically assess and release persons with suspected communicable diseases
Principlism with regard to EVD isolation and quarantine

- **Autonomy**
  - Conflict: isolation and quarantine infringes on autonomy; impact on human dignity, freedom of movement & residence, and freedom of trade & occupation of individuals at risk of having EVD

- **Beneficence, & non-maleficence**
  - Conflicts: rationale for treating patients is good, but how can no harm be done if (i) symptomatic EVD-suspected cases without the disease are isolated with those that have EVD thus potentially exposing individuals to a life-threatening disease, and (ii) some drugs being experimental have toxic S/Es

- **Justice (distributive, retributive)**
  - Conflicts: Drugs, vaccines to non-West African volunteer worker: resource allocation resource
Medical Defense Cover when working abroad:

- Essential
- Although NGOs & charities may cover for medical negligence claims there is usually no protections for professional risks such as health professions council investigations
- Meticulous medical records

Participation in administration of new drugs or compassionate/experimental therapies

- Apply same ethical and legal principles as guided by your country’s professional body
- Consent or other valid authority must be attained before providing treatment or involve patients or volunteers in research trials
- Legal responsibility for giving a person an unlicensed drug rests with person ‘signing the prescription’

Medical error

- Honesty, transparency, report to a senior colleague
- Written report essential while incident is clear and ‘fresh’ explaining actions if anything went wrong
Medical safaris: (ii) seeking care
[Surgeon and Safari, South Africa www.surgeon-and-safari.co.za]

Welcome

Surgery and Recuperation with time to heal away from public scrutiny

In association with a choice of South Africa’s qualified and registered Plastic & Reconstructive Surgeons, Dental Surgeons, Ophthalmic Surgeons and Orthopaedic Surgeons.

Lorraine Melvill invites you the opportunity to experience the benefits of our professional facilitation service you should expect from a reputable company understanding your needs and vulnerability allowing you to make an informed decision, offering you a total private medical / health / recuperation solution and service.

Established in 1999 as an independent medical / health facilitator Surgeon & Safari respects the rights of the medical tourist, adhering to professional codes of conduct.

Surgeon & Safari service offers to:

- Coordinate all medical correspondence with your selected Surgeon;
- Prepare detailed cost estimates;
- Arrange all medical consultations;
- Assist in your preparation for Surgery;
- Fully inclusive Accommodation package at Surgeon and Safari 4 star Guesthouse with all services and support needed when having surgery;
- Make all necessary bookings;

"Each time one of us touches the soil of this land, we feel a sense of personal renewal."
South-South medical tourism & the quest for health in Southern Africa 1 [Social Science & Medicine. 2015; 124: 313-320]

- South African has emerged as an important secondary hub for global medical tourism
  - South African industry positions itself as a cosmetic destination from patients from the North
  - Offerings marketed as “a uniquely African combination” of medical treatment and a recuperative experience (great climate & scenery; wildlife – ‘medical safari’; sea, sun, sand; favourable exchange rate; and world-class medical care)
  - Surgeon and Safari

- But conventional notion that SA is purely a high end “surgeon and safari” destination for tourists from the ‘Global North’ is incorrect
### Medical Tourism Flows to South Africa, 2006 - 2012


<table>
<thead>
<tr>
<th>Year</th>
<th>Total Tourists</th>
<th>% medical</th>
<th>Total Medical Tourists</th>
<th>Total Tourists</th>
<th>% medical</th>
<th>Total Medical Tourists</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>6,204,300</td>
<td>5.1</td>
<td>321,519</td>
<td>1,381,881</td>
<td>0.2</td>
<td>2764</td>
</tr>
<tr>
<td>2007</td>
<td>6,907,562</td>
<td>5.9</td>
<td>407,546</td>
<td>1,413,563</td>
<td>0.2</td>
<td>2827</td>
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<tr>
<td>2008</td>
<td>7,374,889</td>
<td>5.5</td>
<td>405,619</td>
<td>1,406,350</td>
<td>0.1</td>
<td>1406</td>
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<tr>
<td>2009</td>
<td>7,788,801</td>
<td>6.5</td>
<td>506,272</td>
<td>1,348,402</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>2010</td>
<td>5,770,918</td>
<td>6.1</td>
<td>352,026</td>
<td>1,321,624</td>
<td>0.1</td>
<td>1322</td>
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<tr>
<td>2011</td>
<td>6,164,589</td>
<td>5.8</td>
<td>357,546</td>
<td>1,275,679</td>
<td>0.1</td>
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<td>2012</td>
<td>6,689,105</td>
<td>3.9</td>
<td>260,875</td>
<td>1,396,978</td>
<td>0.3</td>
<td>4191</td>
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<tr>
<td>Total</td>
<td>47,000,164</td>
<td>5.5</td>
<td>2,611,403</td>
<td>9,544,477</td>
<td>0.2</td>
<td>13,785</td>
</tr>
</tbody>
</table>
South-South medical tourism & the quest for health in Southern Africa 2 [Social Science & Medicine. 2015; 124: 313-320]

- South-South movement to SA for medical treatment is numerically & financially more significant than North-South movement
  - Three different types of movement:
    - Continent’s elite & middle classes see SA as place where quality medical care is available for surgical (orthopaedic and cardiovascular), oncological and other treatments
    - Patients unable to get specialized care in their own country can be referred by government-funded schemes for treatment in South African public and private healthcare facilities (HCFs)
      Patient referrals formal (institutional) and informal (individual) in nature. Some patients go for treatments not offered by their own countries; others referred by doctors to SA HCFs
    - Greatest growth in recent years to medical migration to SA is from neighboring countries whose public health care systems are in crisis
High demand and informal flow of patients from neighbouring countries => SA government to set up inter-country agreements to recover costs of treating non-residents; also ‘medical permits’ (as of 2002) issued for those staying < 3 months (others enter via a visitor’s permit – max: 90 days)

- Danger for disenfranchised medical tourists (those seeking life-saving drugs, therapies and corrective surgeries not offered in home country) falling out of such agreements is that medical xenophobia in SA may lead to increasing exclusion

SA’s own public health-care system overburdened & underresourced; yet > 90% of people accessed treatments but probably because they are mistaken as local

Emerging evidence that that migrants identified as being migrants (especially Zimbabweans & refugees) are being denied medical care because they are foreign
Activities in South Africa by medical and all tourists, 2007 - 2012

<table>
<thead>
<tr>
<th>Activity</th>
<th>Medical Tourists (%)</th>
<th>All tourists (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>94.5</td>
<td>2.6</td>
</tr>
<tr>
<td>Shopping</td>
<td>82.3</td>
<td>94.1</td>
</tr>
<tr>
<td>Nightlife</td>
<td>48.3</td>
<td>90.8</td>
</tr>
<tr>
<td>Social</td>
<td>33.6</td>
<td>32.9</td>
</tr>
<tr>
<td>Trading</td>
<td>3.9</td>
<td>1.4</td>
</tr>
<tr>
<td>Cultural, Historial &amp; Heritage</td>
<td>2.3</td>
<td>43.1</td>
</tr>
<tr>
<td>Visiting natural attractions</td>
<td>1.8</td>
<td>58.6</td>
</tr>
<tr>
<td>Visited a casino</td>
<td>1.8</td>
<td>14.3</td>
</tr>
<tr>
<td>Beach</td>
<td>1.6</td>
<td>40.1</td>
</tr>
<tr>
<td>Wildlife</td>
<td>1.0</td>
<td>49.0</td>
</tr>
<tr>
<td>Theme Parks</td>
<td>0.9</td>
<td>23.4</td>
</tr>
<tr>
<td>Business</td>
<td>0.0</td>
<td>1.8</td>
</tr>
<tr>
<td>Adventure</td>
<td>0.0</td>
<td>12.3</td>
</tr>
<tr>
<td>Education/Training/Study</td>
<td>0.0</td>
<td>0.7</td>
</tr>
</tbody>
</table>
So, how does Principlism apply to medical tourism?

- Patient autonomy and consent

  - Autonomy: patient’s ability to make an informed decision with clarity and thought about his/her care without undue influence
  - Key factor: competence (capacity) – ability to grasp the essentials of an explanation, rationally deliberate, and choose
    - Competence may be limited by circumstances that are intrinsic (e.g. mental competence and comprehension) or extrinsic (e.g. legally imposed due to age or institutionalization)
  - Magnitude of financial incentives (& marketing thereof) are powerful influences (coercion)
    - Economics should not be the most important or only factor in patient choice & decision making
  - For truly informed consent patients need to know how pre-, peri- and post-operative care will be provided
So, how does Principlism apply to medical tourism 2?

• Beneficence (whether proposed treatment is good for the patient) & non-maleficence (care does not harm the patient)

• Beneficence requires definitions of adequate & optimal care

  ▪ Considerations of complications infection, failed procedure, late bleeding, venous TE, pulmonary embolus, HAIs, etc. that all drive post-op care and hospital readmissions must be carefully considered

  • Who provides post-discharge care and under what circumstances?
  • When patient directs payment to the provider who will deliver follow-up care and how will they be reimbursed?
  • What are the medico-legal implications?
So, how does Principlism apply to medical tourism 3?

- Maleficence

- As patients travel longer distances to seek treatment, safety becomes an issue.
- Some types of care are not legal in all countries or not yet approved (experimental). Travelling to a country where a procedure is not legal is controversial.
- Some countries allow for procedures or processes that are not legal because of potential harm to others (e.g. allowing an individual to source and pay for an organ; commercial hiring of a surrogate mother for childless couples; etc.)
- Home country must bear cost of treating complications in the returning traveler.
- Patient returning home with antibiotic-resistant bacteria (e.g. NDM1 saga) or other acquired infection (e.g. HIV)
So, how does Principlism apply to medical tourism 4?

• Justice 1 - inequalities
  
  ▪ Generally healthier, lower risk patients engaging in medical tourism (‘cherry picking’) – compromise of equity of access
  
  ▪ Onslaught of foreigners seeking medical care might drive up price of same care for locals
  
  ▪ Influx of foreigners could increase wait time for locals ...
Other ethical dilemmas in regard to justice 2

- Driving factors of lower costs in developing countries
  - Lower cost of living
  - Lower wages paid to physicians & other HCWs
  - Low administrative costs & medicolegal expenses
  - Cheaper prices offered by global suppliers of medical devices
  - Financial incentives
    - E.g. Indian Government declare medical tourism an ‘export’ and grant it special tax status ...
    - World bank support for building a private hospital in India criticized as diversion resources from government-run services in a country where, in 2005, <50% PHC had a labor room or laboratory, 1 in 5 had a telephone line, fewer than 1 in 3 stocked essential drugs ...
    - Concern that privatization of health services is diverting resources from the local poor
Other ethical dilemmas in regard to justice 3

- Migration of doctors or diversion into specialist areas where services offered are more lucrative
  - Inequity of healthcare practitioner distribution
  - Easier access of the wealthy over the poor
  - Shorter waiting times for procedures offered to the privileged ‘few’
Mounting concerns over bio-security risks from spread of infections & pandemics by returning medical tourists. The unintended consequences of travel: NDM-1


NDM-1 has arrived: first report of a carbapenem resistance mechanism in South Africa.


Abstract

The New Delhi Metallo-β-lactamase (NDM) resistance mechanism in Enterobacteriaceae threatens to render serious Gram-negative infections untreatable. The NDM-1 enzyme hydrolysates all available penicillin, cephalosporin and carbapenem antibiotics, and is commonly accompanied by additional resistance mechanisms to multiple antibiotic classes. Initially identified as a significant healthcare risk on the Indian sub-continent, it has rapidly become a global problem, posing significant diagnostic and management challenges. Here we report the first laboratory-confirmed case of NDM-1 in South Africa.

PMID: 22273027 [PubMed - indexed for MEDLINE]
NDM-1

The worldwide distribution of New Delhi Metallo-beta-lactamase-1-producing bacteria 1 December 2009–31 December 2012 (n=950)

A. Worldwide distribution of autochthonous published isolates carrying the \textit{bla\_NDM-1} gene
Growth of cross-border HIV transmission with increasing international mobility

Small qualitative study exploring experiences & risk perceptions of men acquiring HIV while living/travelling overseas

Analysis of findings of a semi-structured interview using an adapted form of grounded theory revealed 4 domains of experience:

- Fantasy realized
- Escaping and finding a new self or life
- Living a life less ordinary
- Living local but still an outsider
Living a life less ordinary’ [Sexual health 2014;11:547-555]

- Regular or long-term male travelers have a unique culture within which risk generally and sexual risk and safety specifically is enacted and given meaning.
- Risk part of their personal and professional domains; sometimes high disposable income or employment involving long periods of monotony combined with stressful influence/situations of peer influence that normalize a culture of risk-taking or risk behavior.
- Active risk-seeking, adventure, escape or connection could be key elements for desire to travel.
  - May impact on way risk is understood, relationships are given meaning & response to sexual health promotion strategies and messages.
- Generalized travel health promotion messaging unlikely to be effective in this group.
- Travel medicine practitioners need to understand and explore patient needs more carefully.
- Infection of others in home country & burden on healthcare system.
46 yr old anesthetic assistant nurse (Index case) significantly exposed to ‘imported’ Gabonese primary/source & ‘atypical’ case: 29/10/96

Acute febrile illness 02/11/96

Series of events: delays in both diagnosis and judgments – definitive diagnosis of Ebola v: 15/11/96

Primary/source case traced to convalescent home on 16/11/06 & confirmed to have had Ebola Fever

Cascades of actions and reactions, including patient transfers & resulting in >1000 exposures

Death of patient on 24/11/96 from intracranial hemorrhage & nosocomial infectious complications
Unintended consequences of travel: Ebola, Africa 2014-15

Deaths Cumulative cases

- Guinea: 2535, 3808
- Liberia: 3955, 10672
- Sierra Leone: 4808, 14001
- Italy: 0, 1
- Mali: 6, 8
- Nigeria: 8, 20
- Senegal: 0, 1
- Spain: 0, 1
- UK: 0, 1
- USA: 1, 4
Unintended consequences of travel: Ebola
Conclusions 1

• Travel (human mobility) is increasing & has a significant impact on public health phenomena; global dissemination of infectious diseases is an example of an unintended consequence

• Underlying tenets/principles of ‘Principlism’ (dominant platform of Medical Ethics) are autonomy, beneficence, non-maleficence & justice

• Drivers of medical tourism, an aspect of travel medicine, are strong and raise a number of ethical issues around complex topics that the travel health practitioner might be expected to address

• Socio-economic determinants & health needs will result in a burgeoning demand for medical tourism
Conclusions 2

• Addressing the complex issues around justice inequalities is crucial & policies addressing these are important

• International medical travel stakeholders need to review processes develop consensus policies on identifying accredited facilities with the appropriate that provide safe, high quality care

• Contingency plans to mitigate and manage patients with post-treatment complications must be clearly formulated

• The travel medicine practitioner is frequently the first or last port-of-call to assist patients with decision making based on best available information (i.e. respect for patient autonomy)